August 26, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1587-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 57 year-old female who sustained a work related injury on ___. The diagnoses for this patient include lumbosacral radiculopathy, secondary myofascial pain, status post removal of Dorsal Column Stimulator I Implantable Pulse Generator secondary to rejection and situational depression. The patient underwent an MRI on 10/25/01. Treatment for this patient has included epidural steroid injections, trigger point injections, therapy including aquatic therapy and oral medications. The patient is currently being treated with oral and topical pain medications, physical and occupational therapy, heat wraps and the use of an RS4i stimulator.

Requested Services
Purchase of an RS4i sequential stimulator.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 57 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the diagnoses for this patient include lumbosacral radiculopathy, secondary myofascial pain, status post removal of Dorsal Column Stimulator I Implantable Pulse Generator secondary to rejection, and situational depression. The ___ physician reviewer further noted that treatment for this patient's condition has included epidural steroid injections, trigger point injections, therapy including aquatic therapy and oral medications. The ___ physician reviewer indicated that the patient has been prescribed the RS4i sequential stimulator for further treatment of her condition.

The ___ physician reviewer explained that the patient had been using a TENS unit as of 1/31/03 with good results. The ___ physician reviewer also explained that while the RS4i unit is not exactly the same as a TENS unit, and that there are no randomized, case controlled studies showing that RS4i is superior to a TENS for chronic pain. The ___ physician reviewer indicated that the patient was prescribed the RS4i unit to decrease medication usage and increase the patient's range of motion. The ___ physician reviewer explained that a progress note dated 5/6/03 indicated that the patient has not decreased her medication usage. The ___ physician reviewer also explained that the there is no evidence in the records provided that the patient's range of motion had increased. Therefore, the ___ physician consultant concluded that the requested RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit is not medically necessary to treat this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of August 2003.